Globalization, austerity, and health equity politics:

Taming the inequality machine, and why it matters

Ted Schrecker

Professor of Global Health Policy

School of Medicine, Pharmacy and Health

Durham University

University Boulevard, Thornaby, Stockton-on-Tees TS17 6BH United Kingdom

+44 7918 701305

Theodore.schrecker@durham.ac.uk

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Abstract

Recognition that globalization has an important role in explaining health inequalities has now moved into the mainstream. Much of that role relates to what has been called '[t]he inequality machine [that] is reshaping the planet.' At the same time, more attention must be paid to how the state can tame the inequality machine or compensate for its effects. I argue that governments have more flexibility in this respect than is often acknowledged. With an emphasis on current and recent social policy in Britain, I illustrate the need for researchers and practitioners to focus not only on external constraints associated with globalization but also on domestic political mechanisms and dynamics that may limit the extent to which governments can reduce health inequalities by addressing underlying social determinants.

Keywords

Austerity, globalization, economic policy, inequality, social policy, social determinants of health

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In an important paper on explaining socially patterned inequalities in health, Finn Diderichsen and colleagues argued for understanding these by way of their origins in social stratification – and understanding social stratification, in turn, with reference to 'those central engines in society that generate and distribute power, wealth and risk' (Diderichsen, Evans, & Whitehead, 2001, p. 16). . Drawing in part on their analysis, the World Health Organization's Commission on Social Determinants of Health (2008) assembled a formidable body of evidence linking stratification and economic inequality with socioeconomic gradients in health, which cannot be reviewed here for reasons of space (but see Diderichsen et al., 2012 and Marmot, Allen, Bell, Bloomer, & Goldblatt, 2012 for useful reviews that postdate the Commission's work). Recognition that the progressive integration of national economies and societies into the world economy – globalization – is one of the engines referred to by Diderichsen and colleagues has now moved into the mainstream of health policy thinking (Ottersen et al., 2014).

The relevant pathways of influence that lead from globalization to health inequalities by way of social determinants of health are multiple (see generally Labonté, Schrecker, Packer, & Runnels, eds., 2009; Ruckert & Labonté, 2012; Schrecker, 2014). Global reorganization of production, facilitated by a multiplicity of trade and investment agreements, has offered new profit opportunities associated with 'labour arbitrage' (Roach, 2006) so that (for example) in 2008 there were more than twice as many manufacturing workers in China (99 million) as in all the G7 countries combined, but the Chinese workers were earning US $1.36 an hour on average – approximately four percent of hourly compensation costs in US manufacturing and three percent of those in the Euro area (Banister & Cook, 2011). The results have included relentless downward pressure on wages and deterioration of working conditions in parts of the high income world. Even before the financial crisis, an *Economist* special report in 2006 conceded that 'the usual argument in favour of

globalisation – that it will make most workers better off, with only a few low-skilled ones losing out – has not so far been borne out by the facts. Most workers are being squeezed' (Woodall, 2006, p. 6).

Finance as well as production has been reorganized on a global scale, enhancing the power of investors to shape the priorities of national governments. The head of the International Monetary Fund (IMF) at the time of the collapse of the Mexican peso in 1994-95 commented in the aftermath that 'market perceptions' that a country's economic policies are no longer 'basically sound' can lead to disinvestment that is 'swift, brutal, and destabilizing' (Camdessus, 1995). Combined with the increased importance of finance as a profit centre in its own right ('financialization'; see Epstein, ed., 2005), the result was to create an environment conducive to recurring financial crises of which the most dramatic (so far) swept across the world in 2008. The experience of the past few decades has been that financial crises ratchet up inequality in several ways, whether their scale is national, regional or global (van der Hoeven & Lübker, 2006; Walton, 2009; Halac & Schmukler, 2004; Ball, Fuceri, Leigh, & Loungani, 2013; Marois, 2014). As one illustration, by 2010 there were *more* individuals with more than $1 million in liquid, investable financial assets than in 2007 in nine out of the ten largest US metropolitan areas (Capgemini, 2011). Meanwhile, the number of people receiving federal government food vouchers (food stamps) had risen from 26.6 million in July 2007 to 41.8 million in July 2010 (Food Research and Action Center, 2011); millions more were subsequently added to the rolls.

These and other processes have been described by the editor of *Le Monde Diplomatique* as '[t]he inequality machine [that] is reshaping the whole planet' (Halimi, 2013). Given the body of evidence on social determinants of health, a *core strategic question* for all of us committed to reducing health inequalities is therefore: how much 'policy space' do governments have for economic and social policies that tame the inequality machine? Policy space has been defined as 'the freedom, scope, and mechanisms that governments have to choose, design, and implement public policies to fulfill their aims' (Koivusalo, Schrecker, & Labonté, 2009, p. 105), and in the context

of globalization and health the term is most often used in discussing constraints associated with trade agreements. On the other hand, in his brilliant introduction to an edited collection on inequality, Goran Therborn (2006) wrote that: 'National institutions and processes are crucial for global distribution. National rulers have no global alibi for national privileges and inequalities' (p. 49). His analysis is more sophisticated than this quotation would suggest, but it provides a useful springboard for further explorations.

Without specification of context, rejection of global alibis is too strong. Trade agreements both directly and indirectly limit the options available to governments to improve population health and reduce health inequalities (Blouin, Chopra, & van der Hoeven, 2009; Koivusalo, 2014). The unequal bargaining power in trade negotiations of large, rich economies and small, poorer ones means that the latter may have to make major concessions in order to gain even limited improvements in access to product or service markets (Stiglitz & Charlton, 2004); this may explain, if not excuse, such phenomena as the willingness of developing country governments to accept provisions in bilateral and plurilateral trade agreements that go further than the WTO Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) in limiting access to essential medicines (Correa, 2008). An extensive body of evidence suggests that conditionalities attached to loans from the International Monetary Fund and the World Bank and the 'implicit conditionalities' (Griffith-Jones & Stallings, 1995) demanded by financial markets, backed up by the prospect of loss of access to international credit markets and debilitating capital flight, have seriously constrained the policy options available to many governments in low- and middle-income countries. At least since the 1970s even governments in the United Kingdom, a relatively rich country, have had to keep an eye on how their policies are viewed by financial markets (Keegan & Pennant-Rea, 1979, p. 131-137; Darling, 2011, p. 234-235).

At the same time, elites may use trade agreements to lock in elements of a neoliberal domestic policy agenda in order to prevent future governments from altering these, as Grinspun &

Kreklewich (1994) argue was the case for Canada, Mexico, and the North American Free Trade Agreement (NAFTA). It seems plausible that the current United Kingdom (UK) government is pursuing a similar strategy with respect to privatization of health services and the constraints that would be created by investor-state dispute settlement provisions of the Transatlantic Trade and Investment Partnership (Reynolds & McKee, 2012; Reynolds, 2013; Hilary, 2014); such provisions are a prominent element of NAFTA, and a standard element of many plurilateral agreements now being negotiated. In the macroeconomic policy realm, financial market constraints can be invoked by protagonists within government in support of their existing policy preferences. For example, archival research (Rogers, 2009) on the UK government's response to the sterling crisis of 1976 indicates that the 'crisis provided the government with the room for maneuver to implement its established preferences by altering perceptions about the range of policies effectively within its scope for discretionary action' (pp 972-3), notably with respect to the amount that government could borrow on financial markets (p. 988).

Inter-country comparisons provide support for Therborn's 'no alibi' perspective, even as it applies to relatively poor countries. Drèze & Sen (2013), for example, point out that many countries with GDP/capita comparable to India's, or even poorer, have adopted policies that lead to significantly better performance than India's in ensuring adequate nutrition, education, and access to basic health care. In the high-income world, a major comparative study on labour markets (Gautié & Schmitt, eds., 2010) found that in the mid-2000s low-wage work, defined with reference to the median wage, was three times as common in the United States (US) as in Denmark, and twice as common as in France. Movement toward the US norm was clearly evident over the 1980-2005 period in some countries, like the UK, *but not in others* – despite the fact that the countries in question had 'all been exposed over the last several decades to the same increases in globalization, technology, and competition within national product markets' (Appelbaum et al., 2010, p. 5). There is a clear and unsurprising correlation with rates of unionization and collective bargaining coverage, with about 90 percent of Danish and French workers covered by collective agreements, as against

the US figure of 13 percent. An equally striking picture emerges from the threefold variation in poverty rates, using a standardized measure designed for cross-national comparisons, among high-income countries – a difference that is due primarily to differences in tax and transfer programs rather than to differences in market incomes, as shown in **Figure 1**.

- Insert Figure 1 about here -

At least two caveats are in order at this point.

First, the findings from the labour markets study are pre-crisis observations, and the comparison of poverty rates comes from the early post-crisis period, so it is quite possible that post-crisis trends will show a pattern of convergence as austerity programs take hold. However, Dorling (2014) points out that the trend at least through 2011 was one of growing divergence among countries in the extent of economic inequality, when the comparison is based instead on the share of income going to the top one percent of the population. As he puts it, only some rich countries recently set out to become more unequal. Similarly, in a recent review of trends in inequality Saez and Piketty conclude: 'Inequality does not follow a deterministic process. …. There are powerful forces pushing alternately in the direction of rising or shrinking inequality. Which one dominates depends on the institutions and policies that societies choose to adopt' (Piketty & Saez, 2014, p. 842-843).

Second, countries with high levels of low-wage employment or poverty cannot necessarily make a rapid or easy transition to the other end of the spectrum. The policy outcomes in question reflect a range of political variables including electoral regimes; whether the jurisdiction is a federal or a unitary state; historical legacies of the interaction between social mobilization and political institutions;; and that elusive variable, political culture. Path dependencies both domestic and international must be considered. Thus, scenarios that envision a revival of manufacturing

employment in London, where 32 percent of workers were employed in manufacturing as recently as 1961 (Wills et al., 2010, p. 32), are highly improbable. In some cases, path dependencies reflect previous political choices. For example, having entered NAFTA, it is hard to envision circumstances under which Canada could withdraw from or renegotiate the agreement without doing catastrophic damage to its economy. Assaults on trade unions post-1979 by governments in the US and Britain are likely to have contributed to later, long-term divergence in wage structures. And generically, few governments anywhere in the world can today ignore pressures to compete for direct investment and contract production by way of lower wages and flexible labour market regimes.

Returning to the question of policy space and using the example of contemporary Britain, it is useful to identify two sub-questions that are applicable with some variation elsewhere in the high-income world, and in many other contexts as well. First, to what extent can today's economic and social policy trajectories be explained by external, globalization-related constraints? Second, how effectively is any government chosen under existing political institutions likely to be able to tame the inequality machine? To reiterate, this second question in particular is central to prospects for reducing health inequalities. Public finance is a public health issue.

It seems clear that no external influences of the kind here described can adequately explain the current war on the poor by the Conservative-led government: policies that Sir Michael Marmot (2013), who chaired the WHO Commission, has called 'a grotesque parody of fairness.' No determinative causal pathway runs from the imperative of deficit reduction to income support reforms that will, on one set of calculations, take almost £19 billion per year out of the economy, mainly out of the poorest regions – an impact compounded by cuts to local authority budgets (Beatty & Fothergill, 2013; Special Interest Group, 2013), and one that even *The Economist* has described as brutal (City sicker, 2013). Normative challenges to policies like those just described can make use of a strategy that has been called interrogating scarcity (Schrecker, 2013). As a small-scale illustration, Drèze & Sen (2013) observe that a bill aimed at improving food security in India was

described by critics as 'financially irresponsible' when its officially estimated annual cost was approximately half the revenue foregone each year by exempting imports of diamonds and gold from customs duties (p. 271). The value of interrogating scarcity is underscored by considering circumstances under which scarcity effectively vanishes. The most dramatic recent illustration comes from the aftermath of the financial crisis, when in short order governments were able to mobilize an estimated US$14 trillion in cash and credit guarantees to rescue financial institutions (Bank of England, 2009). That was a short-term emergency, thanks to the ability of the financial services industry to take the world's economies hostage, but the longer term response is instructive. 'The crisis has been warehoused on the expanding balance sheets of central banks, demonstrating just how much scope for policy maneuver there is when governing elites want it' (Green, 2013).

While rising numbers of British households are unable to afford both eating an adequate diet and heating their homes (Butler, 2013; Gordon, 2014), it must be emphasized that austerity is (a) selective, given continued budgeting of billions of pounds for questionably necessary transport and defence capital projects, and (b) not the only option in fiscal policy terms. Much more can be done on the revenue side – a point Piketty (2014, p. 542) has made in the Europe-wide context with the provocative observation that the debts of all European countries could be eliminated by way of a one-time, exceptional tax on private wealth. Underscoring this point, selective austerity is rolling out against a background of income tax reductions for high earners and systematic tax avoidance by major transnational corporations (on the latter see House of Commons Committee of Public Accounts, 2012, p. 7-10; House of Commons Committee of Public Accounts, 2013). One of the most thoughtful observers of contemporary social policy emphasizes that: 'The longer-term goal is to shrink the state, free up the market and set British political economy on a new course' (Taylor-Gooby, 2012, p. 61) - in other words, to continue the Thatcherite project, which has never been explicable with direct reference to the compulsions or constraints of globalization. Analogously, it is implausible to attribute India's comparatively inferior performance on social determinants of health to globalization *per se*, as distinct from the opportunities that globalization creates for capital

accumulation by domestic elites and the resources it provides for them to advance their agendas domestically.

The second sub-question is more complex. Whatever the many failings of New Labour, its leaders made reducing health inequalities and their underlying causes a stated priority, and indeed had some success in reducing child poverty before the crisis (Waldfogel, 2010). We would not expect most of the health impacts of that success to be evident yet. Meanwhile, on some fairly crude measures (notably the likelihood of death before age 65) differences in health between rich and poor areas *circa* 2007 were larger than at any point since before the Great Depression (Thomas, Dorling, & Smith, 2010), leading the authors who reported this finding to conclude that 'the comprehensive but diffuse approaches in official responses to health inequalities are inadequate.'

Mackenbach (2010, p. 1249) has reflected on this record by pointing out that 'it is difficult to imagine a longer window of opportunity for tackling health inequalities' and asking: 'If this did not work, what will?' On the other hand, he correctly observed that 'health inequalities are the result of the cumulative impact of decades of exposure to health risks, some of them intergenerational, of those who live in socioeconomically less advantaged circumstances.' This means not only that reducing them 'requires a massive re-allocation of societal resources' (p. 1252) but also that, even given a serious political commitment, 13 years might not be long enough. The core of his argument, though, is that *if* the failure of the English strategy to reduce health inequalities under New Labour was due to the persistence and widening of economic inequalities – and he is more skeptical on this point than I would be - then 'it is unlikely that a majority of the English electorate would have supported the substantial redistribution of income and wealth that would have been necessary' (p. 1252) to alter that trend. He concluded flatly that 'reducing health inequalities is currently beyond our means,' even though pursuit of the objective should continue as a moral imperative (p. 1252).

Mackenbach here has provided yet another line of argument that the primary political obstacles to reducing health inequalities in high-income countries are internal, rather than external.

However, the probable electoral resistance he anticipates demands explanations as much as it provides them. This is a far larger field than can be canvassed here, but two directions – not mutually exclusive – are worth outlining. The first has to do with framing, and with how 'neoliberalism has the effect of limiting what is sayable, doable and even thinkable' (Rushton & Williams, 2012, p. 165). Illustrative of this perspective is Taylor-Gooby's (2013) assessment that Britain's political left must 'respond adequately to the economic crisis to be seen as competent' (p. 403) and at the same time 'must fit within the pattern of discourse established by the UK media and by opinion-leaders' (p. 409). If accurate, this assessment indicates a need for finer-grained understandings of such issues as how conceptions of competence in economic policy are shaped, and why the 'pattern of discourse' has become impoverished and inhospitable to redistributive policies.

A second line of explanation rests on rational calculations based on the electorate's economic opportunity structures, or at least its perceptions of them. Writing specifically about the US and Britain, Clark & Heath (2014) posit the existence of a 'constituency of the "squeezed but basically safe"' (p. 213), and argue that 'in hard times the exposed are more desperate for help than ever, but the majority ... have come to calculate that it is better to throw their lot in with the haves, than to risk being saddled with tax rises to provide assistance to the have-nots' (p. 202). If this is the case, then we must ask how and why some political cultures emphasize solidarity more than others, and in turn consider questions like whether state-led policies such as assaults on trade unions had effects on the political terrain that go beyond wage structures. A more immediate, and sobering, implication is that in jurisdictions where such a constituency has become established, for whatever reasons, health inequalities and their underlying economic drivers may prove especially intractable.

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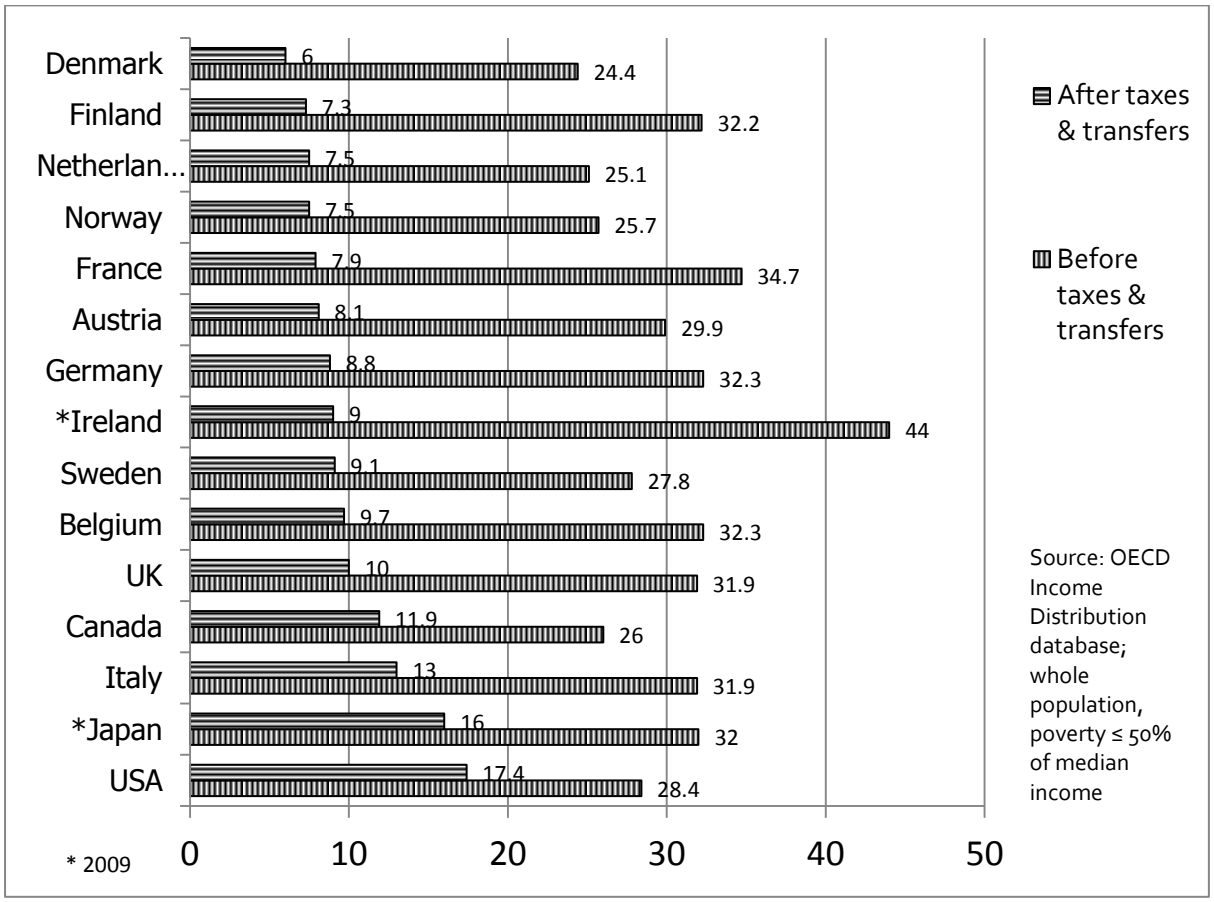
Figure 1. Poverty rates before and after taxes and transfers, selected OECD countries, 2010



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